THE BUDGET, TAXES, AND THE ECONOMY: SHOULD WE CUT ENTITLEMENTS?*

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TODAY'S HEALTH POLICY AGENDA is shaped by two strong and often competing forces—the health care needs of the American people and the tough realities of budget constraints and deficit reduction. At the federal level these forces shape the spending priorities established for health and other federal programs in the Congressional budget process. The budget priorities, in turn, tend to drive health policy and legislative priorities. The actors who shape health care policy and spending approach health care issues from different perspectives that reflect their positions and roles in the legislative process.

The major congressional committees with responsibility for health legislation providing the statutory basis for federal health programs are the Committee on Energy and Commerce and the Committee on Ways and Means in the House of Representatives and the Committee on Finance and the Committee on Labor and Human Resources in the Senate. These committees have responsibility for Medicare, Medicaid, and other federal health laws. They are generally the advocates for addressing health care needs and expanding or improving the health programs under their jurisdiction.

The House and Senate Budget Committees, on the other hand, view their role in terms of the overall federal budget and the allocation of limited federal resources among programs. They see health spending as only one component of their responsibilities. The Budget Committee perspective requires balancing of many competing priorities with an overall goal of constraining federal spending. As might be expected, health advocates and budget balancers view health programs, especially entitlement programs, very differently when analyzing the federal budget and the nation's economy.

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THE STATE OF HEALTH CARE IN AMERICA

Health care is a substantial factor in the American economy and consumes a large share of our national resources. In 1987 $500 billion in public and private expenditures was spent on health care services.[1] This represents more than 11% of the gross national product of the United States. In essence, slightly more than one of every 10 dollars generated in the national economy went towards health services or health-related care.

Yet, despite this substantial expenditure of resources, the United States still faces serious health problems. The infant mortality rate is higher than that of most industrialized nations and progress in reducing the rate has slowed in recent years. Black infants are twice as likely to die as whites with infant mortality rates of 18 per 1,000 births for blacks and nine per 1,000 for whites.[3] These high levels of infant mortality are due in part to the inadequate provision of prenatal care to high risk groups. More than half of pregnant black women receive inadequate prenatal care, as do nearly half of all women with incomes below the poverty level.[3]

Access problems in the United States also relate to the serious gaps in insurance coverage among the American population. Today 37 million people are without insurance coverage from either employer-based plans or public programs. Those without insurance must rely on public services or charity care when illness strikes. Some go without care or delay care until illness places them at substantial risk. For many with insurance, coverage is less than comprehensive. A quarter of the insured population has inadequate coverage.

Even among the elderly population with Medicare protection, serious inadequacies in coverage occur.[5] Medicare requires substantial cost-sharing, leaving many to face insurmountable financial burdens. Medicaid assists only a third of poor elderly people with their health care costs. Moreover, long-term care remains a virtually uncovered expense requiring those who need nursing home care to become impoverished to become eligible for Medicaid assistance.

HEALTH POLICY PERSPECTIVE

The health policy analyst and advocate looks at these problems as consequences of inadequate coverage and lack of financing. Proposals to address these issues use the expansion of health insurance to fill the gaps in public and private coverage. The solutions are built on the premise that expanding

entitlements and program coverage will improve access to care by removing financial barriers to care.

With expanded entitlements as the preferred strategy, infant mortality and inadequate prenatal care are addressed by extending Medicaid coverage to more low-income pregnant women. The problem of lack of health insurance is addressed by expanding employment-based coverage to the working population and Medicaid to the poor and near-poor population until full coverage of all Americans is achieved. Assistance for the low-income elderly population is addressed by expanding Medicaid for low-income people to fill in Medicare's gaps or by broadening Medicare coverage for all elderly people. Finally, solutions to reform long-term care include expanding public financing for nursing home care through Medicare and Medicaid and providing incentives to stimulate private long-term care insurance for both in-home and nursing home care.

In sum, the health policy perspective advocates expansions, not reductions, in entitlements as a means of improving the nation's health. From this perspective, the spiraling cost problem of health care is better addressed by eliminating inefficiency in the system than by cutting entitlements and reducing services to people.

BUDGET PERSPECTIVE

The budget perspective pursues a different line of analysis, beginning with concern over a federal deficit of more than $100 billion in 1989.[6] Large budget deficits are troubling because they raise interest rates, absorb private savings that would otherwise be available for private investment, and slow economic growth over time. Reducing the deficit, therefore, is viewed as vital to restore national savings to levels necessary to sustain economic growth. This philosophy is embodied in the Gramm-Rudman-Hollings legislation that requires automatic spending cuts if Congress does not pass legislation that reduces spending or increases revenues at levels sufficient to eliminate the deficit by 1993.

Against this backdrop of the federal deficit, the budget analyst looks at health care and sees that the United States spends 11.1% of its gross national product on health care (Figure 1). The percent devoted to health is higher in the United States than in other industrialized nations, such as Great Britain (6.2%), Japan (6.7%), Canada (8.5%), and Germany (8.1%). Moreover, not only does the United States spend a higher percentage of its gross national

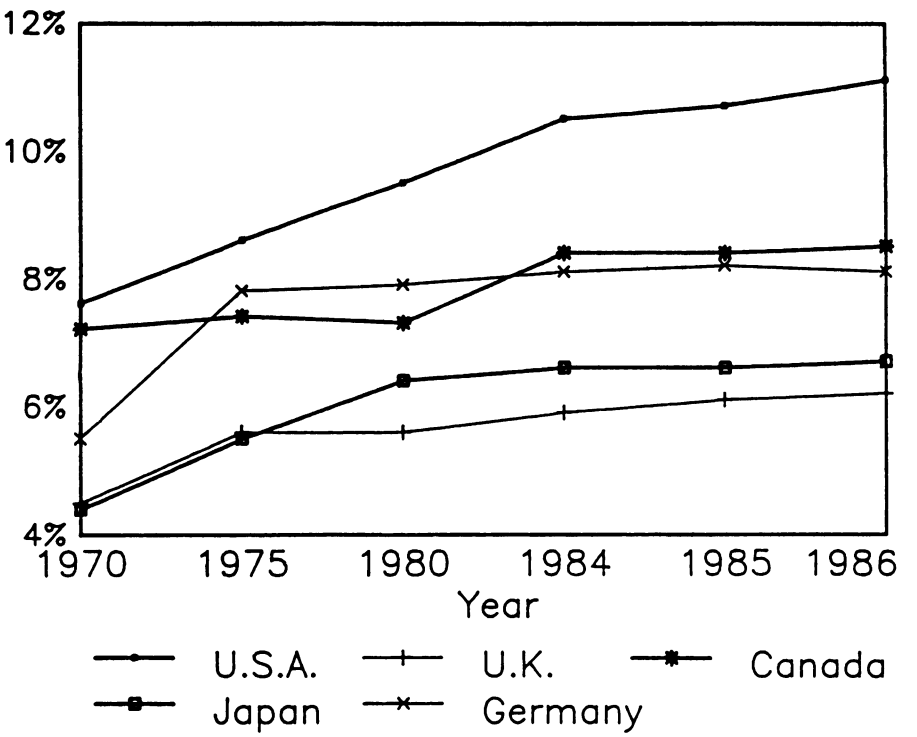

Fig. 1. Total health expenditures as a percent of GDP, selected countries, 1970–1986. Source: reference 8.

product, but health expenditures are continuing to claim a higher and higher share in the United States while spending in other nations has levelled off.

For the budget analyst, the growing share of the federal budget devoted to health care is especially problematic. Within the federal budget of more than one trillion dollars for FY1990, health programs account for more than 12% of all spending (Figure 2). Medicare spending of $112 billion for the elderly population accounts for 9% and federal Medicaid spending of $40 billion for the poor accounts for 3% of all federal expenditures. Other health programs, including biomedical research, accounts for another $8 billion of the $208 billion in nondefense discretionary programs.[6]

As more dollars go to health care, fewer dollars are available for other activities. The spending cut dilemma is compounded because some items in the federal budget are politically or practically difficult to cut. Assuming that Social Security payments are politically untouchable as a means of reducing

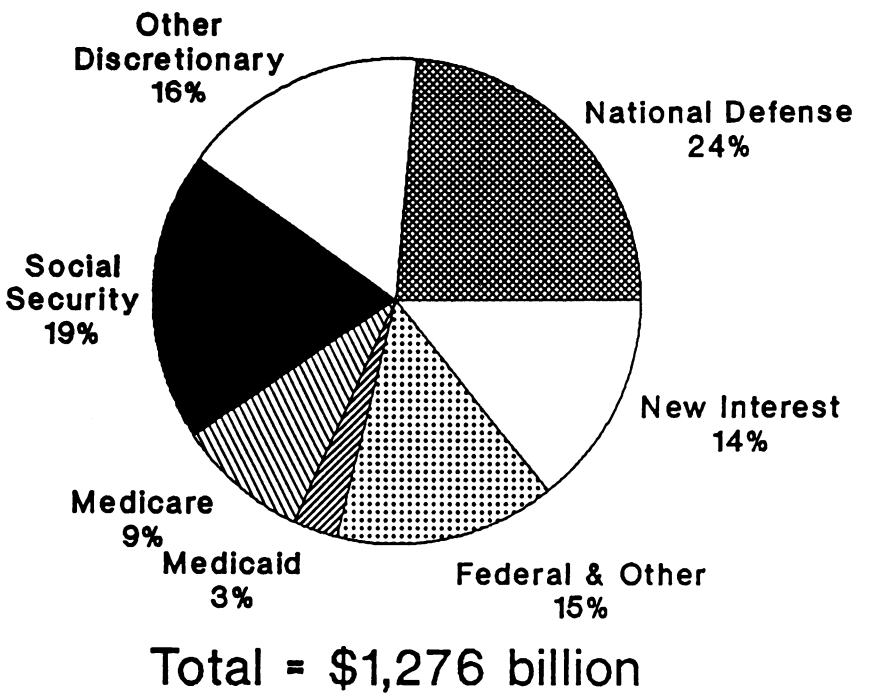

Fig. 2. Projected U.S. government spending FY 1990. Source: Congressional Budget Office Baseline Outlay Projections in reference 6.

spending, almost 20% of the budget is off the spending-cut table. One quarter of federal spending goes to national defense. Cuts in defense spending, however, have also been politically difficult given the administration's priority for increased military spending during the Reagan years. Similarly, interest on the debt is a mandatory federal payment that must be paid that can only be reduced by lowering the deficit. Thus, at current deficit levels 14% of all federal spending is for interest payments on the deficit. In fact, the federal government spends more today on interest payments than health care.

As a result, most cuts in federal spending fall to health entitlements or the 16% of the budget allocated to nondefense discretionary programs. The nondefense discretionary funds represent federal funds for health activities, including biomedical research, food and drug regulation, maternal and child health programs, and community and migrant health centers. But nondiscretionary programs also include federal funds for such nonhealth activities as law enforcement, environmental protection, energy development and conser-

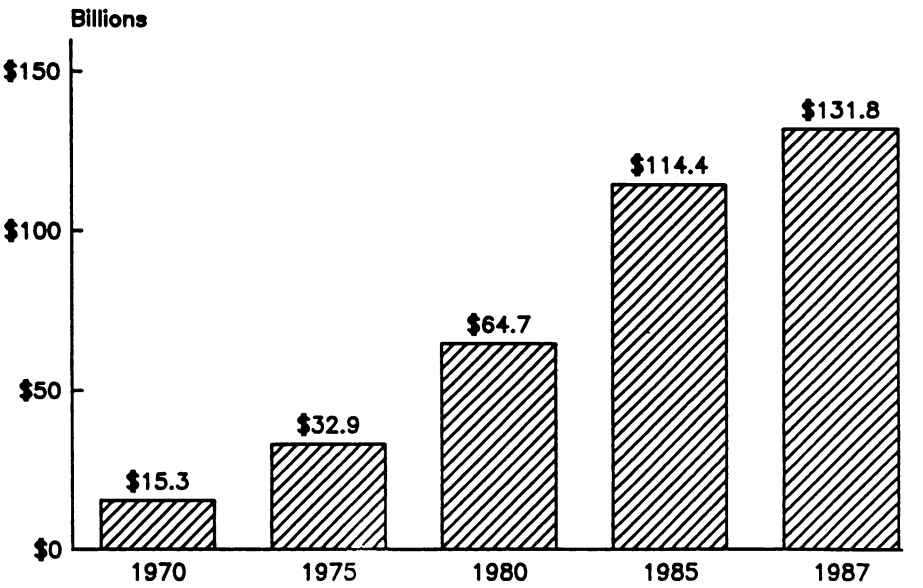

Fig. 3. U.S. federal health spending for selected years, 1970–1987. Source: reference 12.

vation, highway development and maintenance, and space exploration. All of these programs account for spending of $208 billion. If cuts in these discretionary programs are the sole means of solving the deficit and cuts are applied equally, all of these programs would have to be slashed in half to balance the budget. Clearly, such a proposal is unlikely to be politically acceptable because it would destroy the infrastructure of our domestic programs.

Therefore, the budget analyst must turn beyond discretionary programs to find ways to cut federal spending and to reduce the deficit. Health entitlement programs become a logical target. From 1970 to 1980 health care spending grew from $15 billion or 7.7% of federal outlays to $65 billion or 10.9% of federal outlays in 1980 (Figure 3). By 1987 federal health care spending was $132 billion, representing 13.1% of total federal outlays.

Health care spending has been increasing at a rate that far exceeds other elements of the economy and Medicare has been the leading force driving the spending. Almost half of all federal health expenditures are for Medicare. Spending for Medicare has increased from $7.3 billion in 1970 to $35 billion in 1980 and was up to $83 billion in 1987. Medicare accounted for 3.4% of all federal outlays in 1980, but grew to 7.4% by 1988.[7] Medicare's share of federal spending is expected to continue to increase in the future. Over the

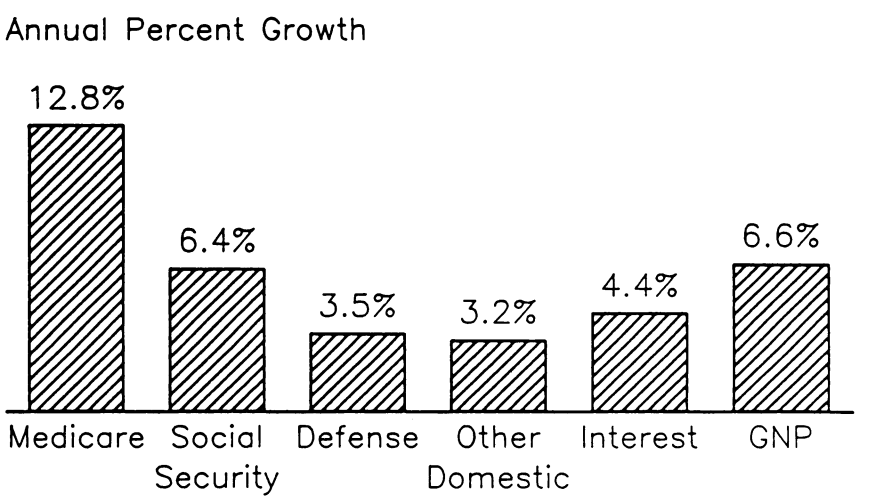

Fig. 4. Projected annual growth rates of selected federal outlays and GNP, 1989–1994. Source: reference 13.

period from 1989 to 1994 Medicare is projected to grow by 12.4% per year compared to a 6.4% annual increase for Social Security, a 3.5% increase for defense, and an overall growth rate for the economy of 6.6% (Figure 4).

The concern over the size of the federal budget and the growing share of federal spending devoted to Medicare has made federal health programs more important and visible targets for cost containment. Holding the line on Medicare expenditures has become a major factor in balancing the budget. For the budget analyst, Medicare is a critical factor in the dollar calculations to balance the budget. The budget analyst's Medicare goal is to get the numbers down.

To determine where cost containment would make the greatest impact on Medicare spending, the budget analyst examines the rate of increase for various components of Medicare spending to identify the areas for savings initiatives. In contrast to an overall projected annual increase of 12.4% for Medicare generally, the hospital component is expected to have a more moderate increase of 10.4% per year (Figure 5). However, physician services are expected to increase by 12.6% and other Part B services by more than 15%. Thus, Part B services are potentially targets for future cost-savings proposals.

Because of its size, any curb in the rate of increase in Medicare spending would clearly have a dramatic impact on overall federal spending. For example, if cost targets had been imposed under Medicare in 1988, the course of future spending out to 1994 could have been substantially lowered. Unre-

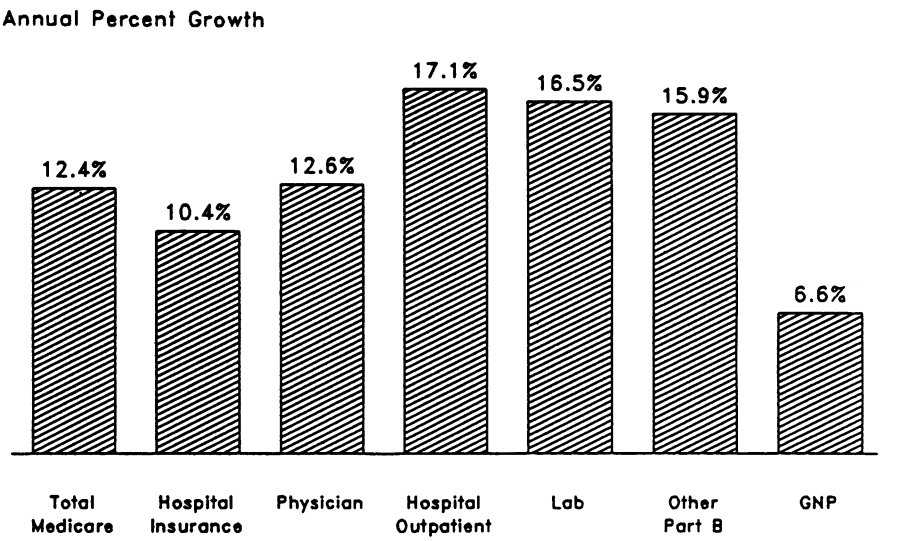

Fig. 5. Projected annual growth rates of Medicare outlays by type of service, 1988–1994. Source: reference 13.

strained, Medicare will grow from $87 billion in 1988 to $180 billion by 1994 (Figure 6). However, if the rate of increase were held to 11% instead of 12.4% per year, spending in 1994 would be $20 billion lower. Holding spending to the increase in the gross national product would almost cut projected spending in half to a level $100 billion in 1994.

Setting and enforcing spending targets has great appeal to the budget analyst, who views Medicare as a program that contributes to federal spending escalation and needs restraint. Cutting Medicare spending becomes integral to the effort to bring the federal deficit under control. For the budget analyst, gaps in coverage and access problems that motivate the health advocate are secondary to the goal of curbing the federal deficit. Cutting entitlements becomes an unpopular but necessary way to achieve a balanced budget in the absence of a tax increase.

HEALTH POLICY VERSUS BUDGET POLICY

When health policy is dominated by budget policy, the numbers and the dollars saved become the priorities. Long-range planning efforts give way to short-term strategies to bring the deficit and spending under control. Spending targets are allocated by program functions, and policy is shaped to meet

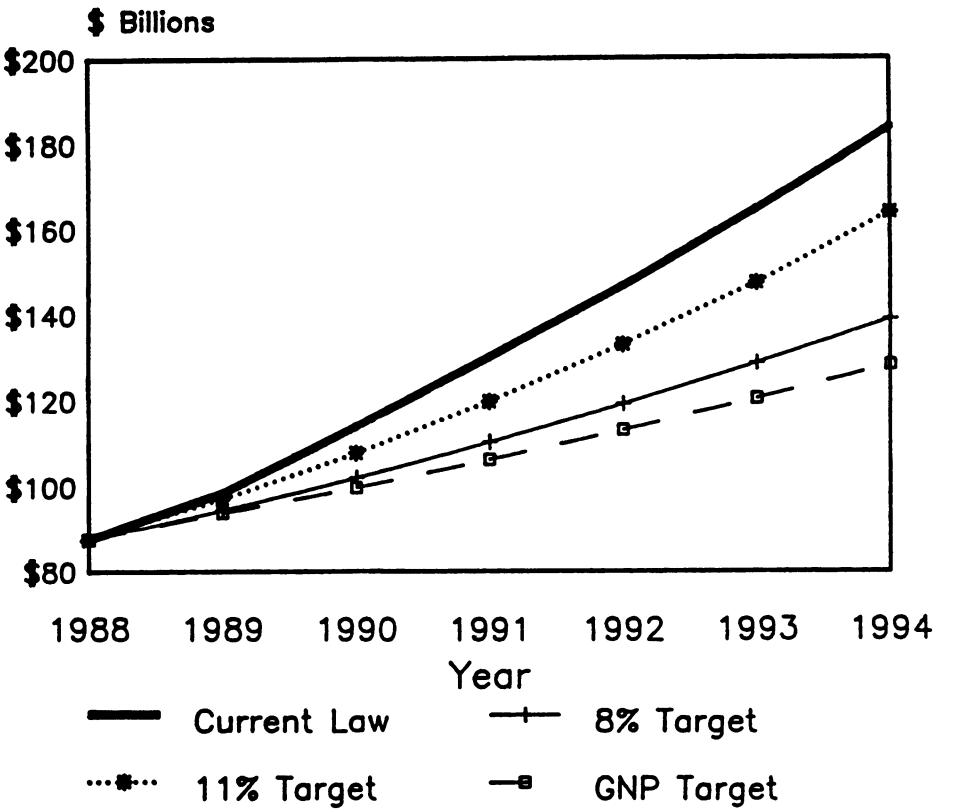

Fig. 6. Projected Medicare expenditures under various scenarios. Source: JHU calculations based on CBO projections. An analysis of President Reagan's budgetary proposals for FY 1990

the spending targets. Health programs compete with each other to get priority for the limited funding that falls within the target spending level set for health functions. Long-range initiatives that might bring savings from improved health over time are suppressed. The savings must be in the here and now. The final outcome results in the promotion of incrementalism at the expense of long-range planning.

But deficit reduction and benefit protection do not have to be mutually exclusive. There is another side to the budget pressure to cut spending to reduce the deficit. The flip side is, of course, that revenues can be raised to offset spending increases and reduce the deficit. Increasing taxes is clearly an alternative to reducing program spending, but it is politically more difficult in the current climate of "no new taxes." For example, doubling the cigarette

tax from 16 cents to 32 cents per pack would raise $2.9 billion in revenues each year—an amount equal to the usual annual spending cut target for Medicare.[6] Alternatively, a temporary 5% surtax on income tax liability would generate $16 billion per year in additional revenue. Yet these and other tax options are set aside by the politics of "no new taxes" while health programs and other services are subjected to the philosophy of "it's less painful to solve the deficit by cutting spending."

CONCLUSION

It is clear that Medicare is at the center and will continue to be at the core of the effort to bring federal spending under control. Cost containment to restrain the rate of growth in Medicare will remain a priority and annual reconciliation budget efforts will continue to cut a few billion dollars a year off growth in sometimes meaningful and sometimes less meaningful ways. Undoubtedly, physician payment reform will take center stage in the effort to curb spending.

Yet it is also clear that the budget deficit this nation faces will not be solved by cutting health programs. We would have to dismantle our federal health programs to balance the budget without raising taxes. Moreover, deep cuts in entitlements are not necessarily a prudent strategy. The deep cuts in Medicaid in the early 1980s were penny-wise and pound-foolish. Today's efforts to raise eligibility and benefit levels for pregnant women and children under Medicaid reflect, in part, an effort to reverse the limits on eligibility imposed when Medicaid spending was cut in the early 1980s.

It must be recognized that increasing revenues is an essential component of any deficit reduction effort. A combination of increased taxes and moderated spending is required to bring the deficit and budget under control. With increased revenues, deficit reduction and protection of benefits are no longer mutually exclusive.

Cutting entitlements is not the bottom line to solving the deficit crisis. In fact, cutting entitlements is the wrong line. In the health care arena, we need expanded—not less adequate—protection. We need coverage for the 37 million people who are uninsured and better, more coordinated care for those already insured. Other countries, like Canada to our north, have achieved comprehensive coverage on a lower percent of the gross national product for health care and with less annual cost escalation.[8] The United States should follow Canada's example and use comprehensive coverage as a means both to improve access and to get a handle on cost containment.

We appear to be returning slowly to the concept of a national health insurance system for this nation. Even leaders of the corporate world, such as Lee Iaccoca of the Chrysler Corporation, have called for universal entitlement under a national health plan as a way to contain costs and improve coverage.[9] The results of a recent Harvard University/Louis Harris survey that contrasted Americans' satisfaction with and access to their health system with the attitudes of those in Great Britain and Canada led the study authors to ask "why not try national health insurance?"[10,11]

Why not try national health insurance? Enactment of a national health insurance system is the best contribution that health policy can make to the budget debate. The budget imperative should become our impetus to enact a national health insurance plan in the United States. A national health plan would eliminate the gaps in insurance coverage and the resulting inefficiency that arises when health care is provided in a piecemeal fashion. With a national health system, we can guarantee basic health insurance coverage to all Americans and provide a central role for government to contain costs for the whole health system, not just for Medicare. Let the message be: "Don't cut entitlements for the sake of reducing deficit; expand entitlements to bring health care spending under control and remove health care as a contributor to the upward spiral in federal spending."

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